"Moving Along" in Psychotherapy With Schizophrenia Patients

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Current treatment of the schizophrenic patient relies primarily on psychopharmacological management, psychoeducation, and family work. If individual psychotherapy is an adjunct, it is generally supportive. Recent focus on determinants of change in classical psychoanalysis suggests that noninterpretive mechanisms may have an impact at least equivalent to that of the well-timed transference interpretation. The author argues that the same noninterpretive mechanisms may be even more important for change in patients in a supportive process. A case study is used to illustrate that such an application of psychoanalytic principles and developmental research can be used to help even the most disturbed patients.

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Since the advent of antipsychotic medications in 1954, the emphasis in teaching residents about the treatment of schizophrenia and other psychotic disorders has been on psychopharmacology. Medication management has proven to be an extremely important, even life-saving treatment for this chronic mental illness.[1] However, nascent psychiatrists also learn that no matter what the etiologies, schizophrenia "occurs in a person with a unique individual, familial, and social psychological profile" and that the treatment approach must be shaped by "how the patient has been affected by the disorder and how the patient will be helped by the treatment." (Kaplan and Sadock,[1] p. 485).

Gabbard[2] gives an elegant example of a schizophrenic patient who, when treated with a full spectrum of techniques—pharmacological, behavioral, milieu, family work, and group and individual psychotherapy—achieved a level of rehabilitation far above what had seemed possible. The case illustrates the principles of technique Gabbard believes essential for psychotherapy with a schizophrenic person: building a relationship, flexibility regarding mode and content of sessions, maintaining optimal distance, creating a holding environment, functioning both as "container" and auxiliary ego for the patient, being genuine and open with the patient, holding off on interpretation until the alliance is solid, and respecting the patient's "need to be ill" (p. 197). These principles are not substantively

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different from the guidelines one observes in doing almost any kind of individual psychotherapy: the difference is in the emphasis on a more supportive and pragmatic mode with very few, if any, transference interpretations.

Outcome studies on the effectiveness of particular modes of psychotherapy for schizophrenic patients have not supported use of the types of intense psychoanalytic processes used for psychotic patients by Searles,[3,4] Bion,[5] and Fromm-Reichmann.[6] McGlashan and Nayfack[7] provide one of the most lucid reports advocating a pragmatic and supportive therapy for schizophrenic patients in their well-known case study of "Jane Cole," which compares psychoanalytic versus supportive therapy over 18 years of hospitalization. (On supportive therapy in schizophrenia, see also the review by Gabbard,[2] summary by Kaplan and Sadock,[1] and article by Lamberti and Herz.[8]) Indeed, Lamberti and Herz[8] state that supportive psychotherapy is the individual psychotherapy of choice for most schizophrenic patients. In addition to being like an "effective coach or good parent," the therapist must "provide education about schizophrenia, promote medication compliance, facilitate reality testing, help solve problems with the patient, and provide positive reinforcement for adaptive behaviors. The therapist should be prepared to give practical advice and guidance when needed, . . . set limits on regressive behaviors . . . [and] collaborate with the patient to . . . prevent relapse." (p. 716).

All of this looms as a tall order for the psychiatrist-in-training. To be a therapist with a schizophrenic patient for whom the psychotherapy "should be thought of in terms of decades, rather than sessions, months, or even years" (Kaplan and Sadock,[1] p. 489) can be daunting. How can the resident, who has at most 2 or 3 years to work with one patient, hope to evaluate the success of a supportive process with a schizophrenic patient? Let me suggest that the hopefulness in a relatively short therapeutic relationship with a psychotic patient—even though the relationship must be terminated—lies more clearly in the domain of noninterpretive events than in the usual domains of reflection, clarification, confrontation, or transference interpretations. This domain can be further described as the therapist's and patient's subjective experiences of the relationship, and particularly the shared subjective experience between them.

The heightened focus among psychoanalysts and psychoanalytic psychotherapists on the relationship between therapist and patient has taken many forms and has many labels. Increasingly, concepts introduced by contemporary psychoanalytic theorists[9–14] speak to the interest in making more explicit just what it is (*beyond* well-timed, accurate interpretations) that allows the process to effect change. Stern et al.[15] also look carefully at noninterpretive mechanisms, the "something more" that effects change in the context of psychoanalytic therapy. Their perspective is that of infant researchers who have spent years examining the mother–infant relationship.[16–23] The affective attunement between infant and mother and the nonlinear dynamic system the dyad creates intrigue Stern and colleagues.[15] They believe the contextual paradigms highlighted by maternal infant research parallel the special moments of intimate connection between analyst and patient; both recognize that something important has been shared that is transforming. They refer to the phenomenon as "implicit relational knowing" and describe the basic units of subjective change within the implicit relational knowing as "now moments" or "moments of meeting."

A "moment of meeting"[16,17] precipitates a change in the implicit relational knowing for both analyst and patient. A moment of open space is created in which habitual ways of thinking about or reacting to events undergo a change, defenses can be modified, and perspective is reorganized. There is thereafter a new way of looking at things. A qualitative shift results, "a new effective context in which subsequent mental actions occur" (p. 906).[15] A moment of meeting is the pivotal event precipitating the qualitative shift. It depends on a "now moment" grasped by both therapist and patient. Both contribute something unique, authentic, and personal. It has little to do with technique or theory.

Stern et al.,[15] basing their conclusions on work by Tronick and colleagues,[22,23] believe that the phenomena that make up implicit knowing have their foundation in affective communication that resembles the earliest caregiving relationships. Such affective communication is the basis for mutual regulation, the bidirectional influence between mother and infant achieved by the actions of downregulation, elaboration, repairing, and scaffolding.[15] Repeated instances of mutual regulation create expectancies that become the stuff of implicit relational knowing. The process is not straightforward, particularly because there are goals to be met in development (and in therapy); expectancies change. Mutual regulation is thus replete with "constant struggling, negotiating, missing and repairing, mid-course correcting, scaffolding," requiring both "persistence and tolerance

of failures on both partners' part" (p. 907).[15] The authors refer to "moving along" as the "trial-by-error temporal process of moving in the general direction of goals, and also identifying and agreeing on those intersubjective and consensual goals" (p. 907). The intersubjective goal is that of object relatedness.

The authors then apply their developmental model specifically to explain how change occurs during psychoanalysis. The moment of meeting creates a shift in the intersubjective relationship, which changes the implicit relational knowing, which in turn allows for "moving along." An intense affective moment, a "now moment" responded to authentically by both therapist and patient, becomes the moment of meeting that changes the intersubjective context. The therapist must respond with something experienced specifically within the relationship and reflective of the therapist as a person. The realization of that moment occurs as patient and therapist become "contemporaneous objects" for one another, leading to internalization of the other.

I would like to suggest that this model,[15] which was developed to explain as much of the intrapsychic change in a psychoanalytic process as transferential interpretations do, may be even more useful to explain initial internal changes in supportive psychotherapy of a person with schizophrenia. I illustrate this thesis with a case report from work with one patient.

CASE REPORT

Patient History. Charles, an African-American male, first presented at age 24 to the low-fee clinic associated with a major psychiatric hospital. He went only once. Ten years later he returned, diagnosed with an adjustment disorder with physical complaints. Psychiatric evaluation and medication management were recommended. Again he did not return. Meanwhile, he worked steadily, earning a good factory wage.

Two years later, when he was 35, local police brought Charles to the crisis unit of the psychiatric center. He was agitated and fearful, complaining of frightening "shadows," decreased appetite, poor concentration, anxiety, and hopelessness. He was sleeping fitfully: he reported having distressing dreams since he was 17. He had ingested a pint of alcohol and became "violent" enough for the police to get involved. The diagnosis this time was paranoid personality disorder and alcohol abuse. Discharge planning included antipsychotic and antidepressant medication, individual psychotherapy, attendance at AA, and return to full-time factory work. Charles's records thereafter are sketchy. He kept two therapy appointments. He did not take his medication consistently. He returned to work, but was laid off two years later because of his increasingly odd behavior. A new intake at the low-fee clinic led to a brief therapy process. His diagnosis had been changed to chronic schizophrenia, paranoid type.

I met Charles halfway through my first year of residency. His pharmacotherapist thought he could benefit from "someone to talk to" and encouraged me to initiate a supportive psychotherapy process. Over the years, Charles's psychiatric history has become clearer. Charles's younger brother, married with children, has a professional career. His older sister suffers from depression. His mother is a successful businesswoman in her early sixties, and his father works for her. Charles says his mother often tells him, "You just need to pull yourself out of this depression. There's nothing to be so scared of." She has also told him that he has always seemed "different" to her: even as a child he did not like to be touched. She refused my offers to see her and Charles's father to help them understand their son's illness and their feelings about it.

Shy and withdrawn in school, Charles felt "different" from an early age, although there always seemed to be some peers who liked him. He longed to be normal and tried his best to relate to others, but school was difficult and he dropped out after the eleventh grade. He had intended to get a high school equivalency certificate, but then started to work and realized that he didn't need it.

He had a couple of girlfriends in high school and developed a serious relationship in his late teens. At age 19, he became a father. Eventually he had four children. He lived with their mother for 13 years. She frequently commented on his strangeness. At times he would get up in the middle of the night and feel along the walls of their small home. Once he was sure there was a "devil" in the children's room, so he got his gun and shot into their room. He immediately "came to himself" and rushed into the room, touching the children to see if they were all right. They were not bleeding, and he was greatly relieved and frightened. He had no thought of how terrified the children and their mother must have been. As much as he wanted to be "normal," to have children, Charles had a hard time being around them. They made him "nervous, climbing all over" him. He could barely stand to touch them, although he occasionally made himself do so. Finally, Charles and his wife separated. The children lived with their mother. Charles was sad, but relieved.

Work was of critical importance to Charles. He took great pride in his ability to run back and forth between machines, always keeping a numerical sequence in mind as he fed in materials. However, he became increasingly suspicious of his co-workers. He began to drink, trying to escape hallucinatory "shadows" and mumbling voices. At 35, he had his first recognized psychotic break as described above. He was grateful to be able to return to the factory, but he did not remain stable. His thoughts became more paranoid. His co-workers "bugged" him. He began to "hide" during work hours. Once, he reported, he "almost choked" a coworker who was trying to get Charles to give him instruc-

tions. Finally his employer fired him and he was put on disability.

Charles tried to attend church, enjoyed the peace of the service, but had increasing difficulty when congregants wanted to socialize with him. At age 37, his efforts to preserve that connection ended. Although he maintained some relationship with their mother, he saw the children infrequently. They "bugged" him and he has been disappointed by their not paying attention to him or, alternately, being around too much, "taking advantage" of him. Occasionally, Charles tries to "do for" his children, but only with great effort and emotional cost. He finds it extremely stressful to be with them. He attends family gatherings at his mother's, but spends much of the time after a holiday dinner watching TV in the basement.

Charles continues to be troubled by fearful perceptual experiences, "shadows" that seem so real that he has "stabbed" his dresser multiple times to try to make them go away. Because of the shadows, he frequently avoids going out at night. He suffers auditory hallucinations—broadcasting, command, and derogatory voices. He isolates himself and feels comfortable only with his uncle and father. At other times, he "allows" a woman friend to visit him, but then can't tolerate her presence for more than an hour and orders her to leave. He himself wonders why she returns. He has no desire for sexual intimacy. Charles's current primary diagnosis is schizophrenia, undifferentiated type, episodic, with interepisode residual symptoms and with prominent negative symptoms—a diagnosis he continues to protest, deny, and "hate." He has said he will "not tell anyone about them" (the shadows and voices) because he so longs to not have this illness. In this simplistic way he believes that if he can avoid acknowledging the symptoms, no one will be able to see how ill he is.

The Supportive Process. Three years have passed since Charles and I first met. At first he had great fear: Would I care about him? Would I overwhelm him with my own agenda? Would he be able to tell me of his loneliness, the voices, the shadows, his fears? I too felt trepidation. What could I possibly accomplish in psychotherapy with a schizophrenic patient? Here I was, eager to practice my nascent "skills" in an expressive process. Why had I agreed to meet a man who couldn't engage in such a process? We had already learned that supportive psychotherapy was the psychotherapy of choice for a schizophrenic patient. Why had I succumbed to the other resident's request?

I had agreed to at least meet him. That first meeting revealed a short, dark-skinned, very obese man dressed in a torn tee shirt, blue jeans, and loafers, wearing a modified Afro, and smelling of cigarettes and sweat. Charles sat quietly, his hands hidden under his shirt and resting on his large belly. His eyes met mine only occasionally as he scanned the room. My voice automatically lowered, became soft and quiet. The meeting was brief—barely 15 minutes. I recall my awareness of his almost palpable fear, his difficulty meeting my gaze, the barely noticeable relaxation of his body as we talked. After a while, I asked him whether he'd like to meet again. Yes, he thought so. We set up a time. He rose, walking slowly, almost shuffling, eyes darting, occasionally turning slightly to look back over his shoulder, and left the building. I mused about this man. He seemed so unable to engage, yet there was something so touching about him and so frightened, like a dark brown rabbit poised to flee. He had already made an impact.

The next week, still frightened, he showed up at the appointed time, and the next week, and the following weeks. In a few months I went on annual leave. He had known this and didn't think he'd need anyone to cover for me, but he knew he could call the low-fee clinic if necessary. When I returned, he told me he'd had one drink and felt sick. Why had he done that? He had become increasingly "paranoid" (his word) and felt as though "bolts of electricity" were shooting through his head. He talked a little about how angry it made him when people "didn't understand" him. I wondered silently if I could ever understand this strange man with the somatic delusions.

Weeks later he said, "I'm gonna drink." There was something so childlike, so teasing, in the way he said it, nodding his head when I replied that he knew that wasn't okay. I wondered if he was doing this because he'd been angry at my absence. "No," he insisted. But he did drink. A friend came over, sat with him, and drank a few beers. They went walking near the train tracks, and Charles tried to "walk into" the side of a passing train. His friend grabbed him before he could quite do it and threw him down the embankment. He was bruised and couldn't drive, and his friend had to bring him to see me. I let him know I was concerned, and sympathized with his aches and bruises. But I also said that when his relationship with alcohol took precedence, it made me wonder how invested he was in working with me. Although hospitalization occurred to me, he let me know he would refuse admission, and it was already days after the episode. Instead, I decided to try to strengthen the alliance while he was too bruised to move around much. I suggested that his friend bring him to see me every remaining day that week. He followed through. He told me that his mother, and "everyone," was angry at him. Was I angry? Some, but mainly worried, sad, disappointed, wondering how much he cared about himself. This sharing of my affect functioned as a "now moment," providing him with an opening to begin to share more. He spoke about how he had been "struggling all his life." He had these "urges," something telling him to hurt himself. People took advantage of him because of his illness. He couldn't remember things the way he used to. His thinking seemed to be slowing down. He was grieving the impact of his illness, and I empathized. But I also said that drinking could slow his thinking. He seemed surprised, but fell back on "needing to get rid of the voices." In spite of his resistance, there was a clearer sense of a shared understanding subsequent to Charles's acting out, a change in the intersubjective context. It was 6 months into the process: it was moving along.

I suggested a case manager and a family meeting.

Charles refused both. A schizophrenic outpatient was looking for some volunteer work in the hospital. Could he help Charles—share experiences, give him a little encouragement? I suggested that Charles meet him. But would I be there? He couldn't do this alone. I recognized his fear, his dependence, and the implicit question: could I assuage his fear? Yes, I would be there. The encounter went surprisingly well. Charles was amazed that anyone else could have the same kind of perceptual experiences he had and still function pretty well, even seem almost happy. Maybe he should try the same medication? The sharing of this experience seemed to open something for Charles, a small alteration, letting his mind wander a little to new possibilities for himself. He asked if I could manage his medications so that he wouldn't have to change doctors every 6 months because of the schedule of residents' rotations. I agreed. He seemed to be allowing himself to assert his wants a bit more without fear of retaliation, to trust me a bit more. The other patient had told his neighbors about his illness, and they still liked him! Charles didn't think he could ever do that. He couldn't even discuss it with his family, his children. Well, I said, his family might be able to support him more if they understood the illness. No, he didn't want that. Anyway, he was having a few good days. Maybe he was getting better. Maybe he would soon be cured. Gently, I tried to disabuse him of this hope. People felt better as they learned how to cope better, when they took their medications that targeted their symptoms. But the medications didn't cure. Charles couldn't accept that.

Then came a period of thoughtful review. "It seems like a long journey," he said. "The whole last few years. This illness has messed up my life. I don't want my family to see. I don't want to have to take a bunch of pills all my life. Something went wrong when I was born. It must have." I listened as he searched for an answer, a reason. Why me, God? Another level of grief shared, a present moment, affectively homogeneous, coherent in content, was moving the process toward the goal of understanding, even if that goal was not explicit.

Nine months of working. He talked to his daughters a little about his illness. Again I offered a family session. This time he agreed. I telephoned his mother. She was too busy. Subsequent calls from his mother urged me to have him committed "permanently" and led me to believe that she feels unable to be involved in a more supportive way with her son. His father wouldn't come alone. Charles voiced his disappointment and began to talk about his children. His youngest daughter's visits made him tense. One day she was visiting while he was "acting afraid," hearing "voices." She sat with him for a couple of hours after she had checked out the house for "shadows." "How nice," I said. "She does care about you." He looked surprised. The next week, he made a foray to the mall, by himself. He stayed only a few minutes. He told me about it ahead of time; he told me about it afterwards. "There were a lot of people there. It was hard." But what a triumph! The present moments in this sequence, in retrospect, had been organized around the affect of delighted surprise, about his daughter's caring and his ability to make a foray into the world by himself. Those moments seemed to shape a new context in which the patient could try out a different behavior.

A year had passed, and I had to plan for my leave. I suggested a case manager at the county mental health center. For months Charles protested. I told him he needed to have a broader support network; it didn't mean he would lose me. I talked about the fact that he had been able to maintain a relationship with me, with the mother of his children, with his children, even if those relationships were uneven. He nodded, eyes wide. Now he asked directly. Would I go with him? I did. The intake worker said it would take a while to find the right case manager.

My leave came and went without incident. Charles's older daughter now came to meet me at her initiative. She worried about him, wished he were more like "his old self" as she remembered him when she was little; that he could have more fun. She wondered if she would develop the illness later on in life. What about her children? We discussed the probabilities. She seemed quite caring. And finally, Charles had a case manager who could go to Charles's home or take him out for coffee. The case manager met with Charles for the first time. Charles actually felt okay with him. I was relieved. The support network was beginning to widen for this very needy and frightened man.

I moved my office again and Charles let me know this was upsetting. The frame had become important. Telling me was even more important. His recognition of the importance of the familiar in our routine and his protest were indirect acknowledgments of the importance of the relationship. I could only partially repair the disruption, but it was a present moment, providing some mutual regulation.[10,22]

Two years after our work began, Charles tried to drink again. He was so tired of this illness, of feeling bad. He thought drinking would make him feel better. Charles began to talk more about the losses he'd suffered because of his illness. He mourned his job and took some pleasure in the fact that occasionally someone from work would come and ask him about the equipment. The company had not found anyone who could work those machines the way he had. He longed to hold that job again. But he also recalled the fear and violent anger he had experienced when challenged. Then, a nascent acceptance: "I don't think I could handle the pressure of working at the factory again." More grieving. Meanwhile, his weekly visits from his case manager were pleasant, and after a year Charles visited the county day program. He attended once but was upset when no one approached him as the group was beginning to leave for a field trip. He did not respond to visual cues of others getting up to leave. He went home instead. Now he felt more anger: he felt cheated when his telephone broke and the warranty was no longer in effect. When he experienced anger, his voices "got on" him. I said, "Anger is a normal feeling, it's normal to be angry when you feel you've been cheated." He was surprised. "Does that mean I'm normal?" "That

means that you have normal feelings, even with your illness." Again he started to play with his medications, not taking them on "good days," taking them on "bad days." His hallucinations increased, and once again he wound up in the hospital after drinking. I started to talk with him about a relapse plan, the need to extend his support system, what to do when he had the urge to drink. He remained resistant, and I suggested that a major impediment to his keeping himself safe and doing better was his refusal to reach out and use available resources. He thought I would be angry, and was surprised at my reaction. He told me, "I can't do this anymore. I promise, I'm not going to drink. I don't even like the taste of it. I have to force myself to get it down." I changed his medication to the newest antipsychotic: its literature emphasized its good effect on negative symptoms and weight gain. He didn't take it consistently. "I want to be cured," Charles said.

Three years into the process. Charles told me his case manager wanted him to try the day care program again, but he had to make a 6-month commitment. He didn't know if he could promise anything for such a long time. Six months pass quickly, I told him. In 5 months, my general residency would be ending. We wouldn't be able to work together after that and we had to prepare. The day care program could help with the transition.

Until this point, I had thought of the psychotherapy process with Charles as primarily supportive. But the events that followed changed everything.

Something More. For Charles and me there had been several affectively attuned moments over the years, brief, without apparent carryover from week to week. Most memorable were times he could speak of losses he had sustained: work, church, family connections.

Now, however, there was a sea change when I told him of my departure some months away. His expression was stunned and, for the first time, he wept. I felt my own tears welling as I struggled to retain my composure. He looked at me, his eyes overflowing, mine too. This was unfamiliar, unexpected. I felt helpless, propelled into this unsettling moment, fighting to stay within my therapeutic role. We sat in silence. It was a clear "now moment," subjectively different, disrupting the usual way of being together that Charles and I had established over the years. It demanded a response, something personal, something real. I stood, picked up a box of tissues, handed him one, took one myself, sat down, and dabbed at my eyes. With those movements, I acknowledged a mutual and sudden sense of loss. The immediate consequence was a silent suspension of the usual agenda, what Winnicott[24] calls "the experience of being alone in the presence of someone" (p. 32) when one senses a real and truly personal impulse and encounter. A new context was quickly evolving.

I waited, then said it had taken time, but he'd grown to trust me. He and I had a real relationship. It had become an important part of both our lives. He said, "What am I going to do?" I said we would have time to figure that out, together. There would be options. But could he talk now about how this news was making him feel? He shook his head no, so I tried to give him words. With each word I spoke he nodded his head, eyes wide, brimming: "hurt, frightened, abandoned, sad." Yes—and angry? He shook his head no; not angry. I offered reassurance—these were normal feelings for him to have, because we had in fact formed an important relationship. He could take pride, even with the sadness, that he had been able to do this with me. It meant he was able to form other relationships as well, that there could be some pleasure in his life. "Does that mean I'm better?" "It means you're coping better, Charles." "Then I'm going to stop taking my medicines." I reflected to him how angry I thought he was, that if he couldn't have me as his doctor, he would show me that he didn't need me. My interpretation seemed to transform his wish for retaliation into sadness and admission of both loss and dependence. I had attempted such interpretations of his anger before, but they had met only denial. He looked at me sadly, the flash of anger gone. "I don't know what I'm going to do." I continued trying to help him give voice to the overwhelming feelings. About 40 minutes into the hour he said, "I've got to go home." Struggling to keep his tears at bay, he rose and left the office. I sat stunned as the door closed after him and the tears rolled down my face.

The next week his case manager brought Charles. He had been hospitalized with pancreatitis. He'd been frightened, he said, and hurt about my leaving him. He hadn't heard at all "a few months from now." The moment I had said I would not be able to continue treating him was the moment of abandonment, the end of being together in our accustomed way. It was a moment of recognition encompassing many emotions. Gently I encouraged him to talk more about his feelings. It was very difficult for him to admit his feelings about me. But I insisted: it was very important to talk about it so that he wouldn't have to act it out or hurt himself. Giving voice to the pain could ease it. Again, moments passed; his eyes filled with tears. At one point he said, "Who will care for me again, the way you do?" I recalled how frightened he had been the first time we met. He said, "I won't be able to tell anyone about the shadows again, the voices. Not ever." I said, "You grew to trust me. It took time, but you did it, even though you were afraid." "Will you find someone for me who cares?" I would try very hard. "Will I see you next week?" I replied, "Yes, and every week until the end of June." He clutched his abdomen. "I simply can't drink anymore." In great discomfort he walked down the stairs. I walked behind him, saying he should be careful not to fall. He turned to look at me, smiled, and said, "Then I'd hurt even more." I smiled and said, "We sure don't want that, Charles." It was another signal moment, the gentle synchrony of smiles at his little joke expressing affection, a recognition of the pain and of the caring between therapist and patient.

The third session after my announcement produced another shift. Although I'd been aware for some time that Charles was not compliant with his medication plan, he was

now quite aware of the correlation between his being upset and the increase in his psychotic symptoms—the voices, and "shadows." He had stopped taking his medications when he drank. Now, we discussed increasing his antipsychotic medication. "Is there anything else?" he asked. I thought out loud about something more potent. He seemed suddenly clearer about his need, more direct in his demands. Now Charles could also acknowledge that his family rallied around him during this last breakdown. Even his son, whom he hadn't seen in a year, came over. His mother was concerned and "didn't want me to die." This recognition marked a change in the way he looked at himself in the context of his family. I pointed out that everybody has mixed feelings about everybody else, including Charles about me. Again he denied he was angry at me—only sad. I said that I imagined there was a wide range of feelings inside him—anger, sadness, loss, betrayal. He nodded his head at all except "anger," looking me straight in the eye. He said then, "It doesn't make sense for me to be mad because I know you have to move on." I said, "It may not make sense in your head, but it makes a lot of sense in your heart, where those feelings have been buried so deep." "I don't know what to do with these feelings," Charles said. "We'll keep talking about them." This "moment of meeting" altered the realm of what was implicitly relational and took the interaction into a more expressive mode.

In the fourth session, words poured out. Charles reviewed his earlier history. I had heard most of it before in bits and pieces, but this review was more intense, complete, and protracted. He brought additional information, that his biological father had abused both his sister and him, that his last name was that of the man who had later adopted them both. He initiated discussion of sexual issues for the first time. He expressed more anger and resentment at his family, although some of this seemed displaced from me. I wondered if he wasn't trying to protect me a little. He admitted to a "little bit" of anger at my "abandoning" him. He talked again about the many losses his illness had created. His increased talk and heightened affect were remarkable.

Charles cancelled his next appointment. Concerned, I called him. He was feeling too apprehensive to leave his house, but agreed to reschedule the next day. His increasing fears were vague; no voices, just a sense that something might happen. Another session centered around medication. He seemed better able to absorb the information I gave him than in the past, and he asked pertinent questions. He took the printed materials I gave him and agreed to augment the antipsychotic to try to abate his apprehension.

Sixth session: Prior to this session, severely depressed, Charles deliberately drank again and wound up in the hospital, wanting to end it all. He couldn't stand this illness anymore. When I used the word "schizophrenia," he said angrily, "I don't have that." I said I thought his denial was making things worse. He seemed surprised. Did he have responsibility for doing better or worse? I recalled that he had done better before he drank—before he learned I would be moving on. He admitted this. He said his case manager had suggested that he have his medications and therapy taken care of at the county mental health facility. He thought I was trying to "get rid" of him. Again we processed his anger, his disappointment, his sadness at losing me. This time, he brought up the anger himself. He didn't want to keep trying. I told him that it was sad for me too, especially because he didn't seem to feel he could keep me in his mind or heart if we didn't see each other. It made me feel as though he was throwing away the three years of work he and I had done together. His tears welled. "Everyone's mad at me, my sister, my mother, my kids, now you." Did I look angry? "No." But I was sad, as I saw him reversing the progress he'd made. "What progress?" I reminded him of his nascent ability to talk about his feelings, to experience them, his expanded relationship at the county facility, his children rallying around. He seemed surprised and I pointed out that he focused on the negatives, which were indeed serious, but there were hopeful areas. As he left he said, "I have to go, but I'll be back next week." This was another moment of knowing, an expectancy confirmed.

Comment. Those last few months with Charles were incredibly powerful. I continued to have a heightened awareness of my own feelings, as well as of my impact on this man. The relationship deepened, the therapy became more expressive, the content more affectively laden. I could make transferential interpretations of our relationship which Charles, for the first time, seemed to accept. It seemed to me that Charles changed more in that short time than in the previous two and a half years. There was much to be done. We had to more fully address his dependency and strengthen his responsibility for himself. Also I had to continue to take my own risks, to venture a more open use of myself in the therapy of this vulnerable man.

Until that initial moment of meeting, I had provided no transference interpretations in the therapy that Charles seemed able to use. But since then there have been many explicit references to the therapist–patient relationship, many instances of "something more." Some of the subsequent changes Charles has made can be seen as the result of the ability to tolerate transference interpretations of our relationship. I suggest, however, that preceding this new mechanism and key to the changes were the "now moments" of person-to-person communication and the subsequent "moments of meeting" that emerged in the explicit references to that relationship. One might argue that initiation of the termination phase created the pressure for change. This does not obviate the point that the cause of change, that moment when we could share a mutual grief, has been fundamental to the evolving relationship. Before that event, interpretation was seldom attempted and never effective.

Charles demonstrates very little "insight." He cannot explicitly declare understanding of his illness, thoughts, or feelings. But the implicit is very clear—that I care about him, that we have a relationship, that he has felt safe with me. To some extent it has been conveyed procedurally by an empathic and pragmatic approach. The tacit processes

operating in this supportive therapy were many: the frame, quiet tones of voice, nonchallenging acceptance of Charles's explanations, acknowledgement of his concerns. Recently he has begun to describe his feelings more openly. With the use of affective words, the implicit is becoming more explicit, declarative, expressive.

I also experienced a transforming change in that memorable session. I don't think I knew before then how deeply my caring went, just as I don't think I had appreciated how much I meant to Charles. This novel moment had indeed rearranged the "implicit relational knowing" for both Charles and me, taking on a "cardinal importance as the basic unit of subjective change" (p. 906; this and all further quotations refer to Stern et al.[15]). Thereafter, the intersubjective environment did change. It was clear in the subsequent affectively full sessions, in the increasing ability to verbalize feelings, in the recognition that he and I had "been there before." Our exchanges thereafter occurred in a different context. To paraphrase, there was a new effective context in which subsequent mental actions—affective and verbal exchanges—occurred, now shaped by past exchanges and reorganized. There was a sudden qualitative shift to knowing what was in the other's mind about the nature of the relationship without words. Now I could make it more explicit for Charles.

DISCUSSION

Stern et al.[15] have found ideas that undergird their thinking about change during the psychoanalytic process in the mother–infant dyad theory of development. The optimal progression of infant development calls for a caring other and an environment in which mutual awareness, goal-direction, and regulation are the central activities. Each party brings his or her own capabilities, influencing the other's adaptive maneuvers. Did Charles shape my adaptation to him? Definitely. I did things under the umbrella of support that an analyst would never normally do—calling him at home when I knew he was doing poorly; talking to family members, his lawyer, his case manager; providing psychoeducation and diet information; accompanying him to his intake appointment. I kept the affective tone and volume of my voice low. Did I shape his adaptation? I think so—he expanded his support network, achieved some acceptance and comprehension of his illness, accepted more support from his children, and resigned himself to not engaging in stressful work. His affective tone became amplified in our sessions.

The goals of our work were agreed upon tacitly rather than explicitly and moved forward over time with plenty of trial and error—the "moving along" process. To heighten Charles's or my affective experience of our relationship had not been a conscious goal, but this did occur. Clarification of that experience became an important development for both of us—for Charles to recognize that he could feel, like "normal" people, and for me to recognize the power of the relationship in both directions. Like the mutual regulation process between infant and mother, moving along with Charles not only was unpredictable and indeterminate, but also gave rise to something new, the "emergent properties of the dynamic relationship, suddenly realized in a moment of meeting . . . jointly constructed . . . hinging on a specificity of recognition" (Stern et al.,[15] p. 908). As a result of the alteration of the implicit relational knowing, I hope Charles will eventually be better able to engage with the world. He has already been better able to engage with his case manager and me. He asks more questions, takes more responsibility for understanding his medications, and sees himself as more competent.

My goals were to help Charles widen his support network, take his medications consistently, stay away from alcohol, accept and grieve the losses his illness imposed, and begin to appreciate and emphasize the positive features in his life. Charles's agreement with these goals fluctuated, as did his medication compliance, his sobriety, and his acceptance of his illness and its consequences. Eventually, his desire for continued dependence on me and his need to hang on to the handicaps presented by his illness were clarified by his resistance and acting out. We made the goals more verbally explicit as the termination phase was initiated, negotiated, and renegotiated. There continued to be a freer acknowledgment of the changing affective relationship between us. Further clarification and resistance were made more explicit within the changing context of the intersubjective environment. The moving along became more and more palpable as additional present moments continued to change the quality and function of the process.

A "present moment" is defined as "a unit of dialogic exchange that is relatively coherent in content, homogeneous in feeling, and oriented in the same direction towards a goal" (Stern et al.,[15] p. 910). Both for Charles and for me, many of these present moments consisted of mourning, a sadness that shifted back and forth, regulated by changes of topic, as I tried to adjust to his growing expression of affect. There were disruptions followed by repairs as Charles struggled to get back on

the wagon, back on his medications, and back to trusting me. These recurrent sequences and the expectancies surrounding them, including Charles's realization that I would continue to care and continue to meet him following a setback, were building blocks for internalization and object relatedness. Thinking about them in this way helped me tolerate the disruptions.

Stern et al.[15] define "now moments" as a special kind of "present moment," subjectively and affectively "hot," pulling one more actively into the immediate relationship. They take on this quality because the familiar intersubjective environment of the therapist–patient relationship is suddenly called into question. These threatened ruptures in conventional sequences call for a specific, personal response that, according to the authors, cannot be prescribed. Now moments are different from usual present moments. They demand novel behavior from the therapist, perhaps a decision to take a risk and seize a unique opportunity. Expectancy or anxiety may be in the air, as "the analyst intuitively recognizes that a window of opportunity for some kind of therapeutic reorganization or derailment is present, and the patient may recognize that he has arrived at a watershed in the therapeutic relationship" (p. 912). All of this was the case in that crucial sixth session. There was a moment of opportunity for me to prepare Charles for the termination. I took it, and there was a "moment of meeting"[15] when we were both in tears. It presaged an emerging quality of this complex relationship—the potential for emotional closeness, which had never before seemed possible. Charles's tears demanded a new kind of response from me that indicated a sharing of my subjective state with him. Each of us actively contributed something of ourselves in the construction of that moment.

According to Stern et al., when therapist and patient experience and explore the now moment together, they can create a "moment of meeting." They reveal signature aspects of their individuality, partially lowering the masks of their dyadic roles. The reactions that follow must be intuitively shaped to match the singularity of the moment. The intersubjective context changes, as does the implicit relational knowing between patient and therapist. In my mind, these processes clearly describe what happened in that first termination session and in all subsequent sessions. I might have reacted differently, turning away so as to hide my own emotion. Instead, I acknowledged my sudden grief and his by a simple action, so that, in a moment of meeting, the transference and countertransference aspects were at a minimum and "the personhood of the interactants, relatively denuded of role trappings, [was] put into play" (p. 915). One might say that by grappling with the loss of his relationship with me, Charles was also grappling, in the transference, with the losses in his life. But this explanation misses the most important point that linchpin moments occur around which the entire relationship suddenly and dramatically changes in an episode of mutual affective attunement. It was only thereafter that transference interpretations could be accepted and effect change.

That "now moment" had an enduring effect. It lingered in the room in which we met and permanently changed the intersubjective landscape of this particular therapy. Stern et al.[15] describe such moments well with regard to the psychoanalytic process:

> It is misguided to assume that the complex emotional being of the analyst can be (or should be) kept from the sensing of the patient, "sensings" based on the operation of a highly complex system that is always functioning. . . . The operation of this system constructs the "shared implicit relationship," which consists of a personal engagement between the two, constructed progressively in the domain of intersubjectivity and implicit knowledge. . . . Such knowings endure over the fluctuations in the transference relationship. (p. 916–917)

Stern et al.[15] have developed the concepts of now moments, present moments, and implicit relational knowing from their experiences in psychoanalytic situations characterized by a particular frame that brings unconscious mental processes to awareness. I maintain that these sensings operate within nonanalytic therapeutic relationships as well, where change based largely on transference interpretations is not the goal—where the process is supportive, more flexible, and patently interactive. (I have come to wonder, too, if these "knowings" that endure are not similar to the knowings of most, if not all, intimate relationships.) The result of such moments for Charles and myself was the rapid creation of a new dyadic state. It might even be the case that noninterpretive mechanisms of change become more important as the nature of the therapeutic process moves along the continuum from expressive to supportive.

In the course of an analysis, some of the implicit relational knowing becomes transformed into conscious

explicit knowledge. Such privileged moments in which the unspeakable becomes spoken can occur in a supportive process with a schizophrenic patient as well.

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